

**COMMONWEALTH OF KENTUCKY
DEPARTMENT FOR MEDICAID SERVICES
and/or
KENTUCKY HEALTH CARE PARTNERSHIP
EPSDT SPECIAL SERVICES SHORT FORM
(Currently Enrolled Under Kentucky Medicaid Services—see exclusions below*)
PROVIDER APPLICATION**

1. _____
Provider Name—or Name of Entity Enrolling
☐ Applying as Individual ☐ Applying as Entity/Group
 2. _____
Doing Business as (DBA) *(Other names also know as)*
 3. _____
Current Medicaid Provider Number
(Must be currently enrolled non-excluded provider to use this form.)*
 4. _____
NPI (National Provider Identifier) Number
 5. _____
Type of Service
 6. _____
Date Provider Requests Effective Enrollment
 7. _____
Name of Individual with Signature Authority
 8. _____
Title of Individual with Signature Authority
 9. FEIN (if applicable): [][][][][][][][][][]
 or Social Security Number [][][][][][][][][][][][][][][][]

I understand that all elements of my current agreement with Kentucky Medicaid will be met under EPSDT Special Services enrollment activities as further authorized below.

Provider Authorized Signature: I certify, under penalty of law, that the information given in this form is correct and complete to the best of my knowledge. I am aware that, should investigation at any time show any falsification, I will be considered for suspension from the program and/or prosecution for Medicaid fraud. I agree to abide by the Medicaid Program terms and conditions listed in this document, and I continue to hold a license/certification to provide service corresponding to the information above and for which this agreement applies. I hereby authorize the Cabinet for Health Services, the Kentucky Health Care Partnership to make all necessary verification concerning me and/or my medical practice/facility, and further authorize each education institute, medical/license board or organization to provide all information that may be needed in connection with this additional application for participation in the Kentucky Medicaid Program. I further certify that, if I keep medical records on an electronic database, those records are confidential and patient privacy is protected (KRS 2005.510).

***EXCLUDES PRIMARY CARE, RURAL HEALTH, IMPACT PLUS, NON-EMERGENCY TRANSPORTATION, QMB ONLY, AND WAIVER SERVICE ONLY PROVIDERS.**

Provider Signature:

Health Care Partnership Signature: _____

Name (please print): _____

Name (please print): _____

Title: _____

Title: _____

Date: _____

Date: _____

Department for Medicaid Services Signature:

Name (please print): _____

Title:

Date: _____

Please return form to:

Kentucky Medicaid Provider Enrollment
P.O. Box 2110

Frankfort, KY 40602-2110